

Washington State Employee Assistance Program (EAP) Network of Contracted Provider Assessment

Complete this form after the initial visit and return by fax to EAP at 360-664-0498 within 5 working days following initial visit.

EAP Referral Number:

Presenting Problem: Provide a brief description of presenting issue and include duration, severity, pertinent history, and a brief mental status.

Precipitating Event: What happened to bring client in today, why now?

Risk Factor: Note type of risk and level of risk.

If risk is present, document the safety plan discussed with client.

Impact on Job Performance: Assess the impact of presenting issue on job and include performance, attendance and interpersonal relationships.

Treatment History: Indicate type of treatment, level of care, and dates of service.

Chemical Dependency	Level of Care	Dates of Service
Mental Health	Level of Care	Dates of Service

Current Treatment: Indicate type of treatment, level of care, and dates of service.

Chemical Dependency	Level of Care	Dates of Service

Mental Health	Level of Care	Dates of Service

Substance Use/Abuse (check substance of choice)

- | | | |
|--|--|-----------------------------------|
| <input type="checkbox"/> Amphetamine | <input type="checkbox"/> Opiates | <input type="checkbox"/> Steroids |
| <input type="checkbox"/> Cocaine/Crack | <input type="checkbox"/> Poly Substance | <input type="checkbox"/> Other |
| <input type="checkbox"/> Marijuana | <input type="checkbox"/> Prescription Medication | <input type="checkbox"/> None |

Addictions (check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Food/Eating | <input type="checkbox"/> Sex-Pornography |
| <input type="checkbox"/> Gambling | <input type="checkbox"/> Spending |
| <input type="checkbox"/> Internet/Computer | <input type="checkbox"/> Other |
| <input type="checkbox"/> Religion | <input type="checkbox"/> None |

Health/Medical Concerns:

Medications: Include prescription(s) and OTC.

Social Support Network: Include self care activities.

Relevant Family History: Include mental health, substance abuse or risk issues, treatment, and medical concerns.

Provider Name (print): _____

Provider Signature: _____ Credentials: _____ Date: _____